

Ubl said at a news briefing in Washington on Tuesday. The industry is lobbying hard against the tax, but Ubl says it supports other elements of the legislation, such as finding new ways to compare which drugs, devices and treatments work best.

Senate Finance Committee staff, speaking to reporters Monday, said the device tax is a flat amount based on each company's market share, not product prices, a provision meant to discourage passing the fee to consumers.

The controversy about the device tax illustrates how difficult it is for lawmakers to find ways to pay for their ambitious health care ideas. For months, proposals have come and gone—and come back again—from fees on soft drinks to levies on the wealthy. A windfall-profits tax on health insurers and an excise tax on expensive individual health policies are under consideration. Device makers are just taking their turn in the hot seat.

"Congress has a not-in-my-backyard problem in health reform," says Robert Laszewski, an Alexandria, Va.-based health policy consultant. "Everyone wants it, but someone else has to pay for it."

PLUSES AND MINUSES

The health care debate in Washington might seem a long way from this community 2½ hours north of Indianapolis. But the topic is top-of-mind for the executives who run the device companies, the physicians who use the products produced in the plants, and people seeking jobs in the industry.

Funk is among the growing number of uninsured in Warsaw and its surrounding area. About 19% of people here have no health insurance, compared with 15.4% nationally, according to the most recent census data.

For Funk, the proposed tax is "a toss-up." If health reform is approved, he would likely qualify for subsidies to help him buy insurance. But the tax might make it more difficult for him to find work in the industry.

Today, device makers employ about 6,000 people in Kosciusko County, accounting for nearly 19% of the county's private-sector jobs, according to a September report from BioCrossroads, a group formed by venture capitalists and philanthropic organizations to boost the life sciences industry in Indiana.

"It's the only thing that provides a ray of sunshine in that part of the state," says Robert Guell, professor economics at Indiana State University.

Jobs run the gamut, from Ph.D. chemists to machinists. Workers at Biomet and the other plants use high-tech computerized lathes to craft hips and knees from titanium. At Zimmer, which has its own foundry workers in heat-protective suits pull molten-hot molds of joints from giant furnaces. Upstairs, scientists in nearly soundless offices research the next advance in device technology.

Medical device jobs in Kosciusko County pay well, averaging more than \$81,000 annually, according to BioCrossroads.

For a time, experienced workers were often lured from one company to another.

There was so much movement, "you almost had to keep a scorecard to know where your neighbor was working," says Thomas Krizmanich, an orthopedic surgeon who lives and works in Warsaw. He says he has to be careful not to offend patients who work for one of the three big device makers by implanting them with competitors' products.

"Every company would like you to use 100% of their product," Krizmanich says. "It can be difficult to make three companies happy."

The sagging economy has slowed job hopping—and hiring—in the past year. In August, unemployment in Kosciusko County,

which includes Warsaw, was 11.6%, vs. the national average of 9.7%, says database service Proximity. But that was far below that of neighboring Elkhart, where the jobless rate is 16%, in part due to a sharp downturn in the recreational-vehicle-building industry.

LEAVING THE AREA?

The proposed tax on device makers is not the only issue dampening future employment prospects here.

Other countries are offering huge incentives lure device makers overseas, where labor costs and other expenses may be lower.

Zimmer Holdings and Biomet already have manufacturing plants in Europe and China. And while Biomet's Binder says those plants mainly serve emerging markets, he acknowledges that some lower-skill production jobs have moved overseas.

It's unlikely that orthopedic device manufacturing will leave the USA entirely because the high-tech skills are hard to transfer, says Larry Davidson, director of the Center for the Business of Life Sciences at Indiana University.

"What has been helpful for that industry and will continue to provide jobs in the U.S. and Indiana is that it's harder for that industry to separate the technology and product development from the manufacturing," Davidson says.

Others are not so sanguine.

"It's conceivable that (device makers) could move everything eventually," says Nick Deeter, president and CEO of OrthoPediatrics, a Warsaw-based firm that develops orthopedic devices designed for children. He buys components from manufacturers based in the USA and abroad. "Machines do all the work now. Someone starts them and stops them. Even though it's a high-tech product, it doesn't take a skill." Other states and countries have tried to get Deeter to move his headquarters.

"I have a pile of business cards from companies in Ireland," he says. "Akron, Ohio, recently offered us a \$3 million grant to move." But he stayed, with the help of \$4.4 million in grants and other incentives from Indiana.

The ongoing recession means job openings in the device industry are fewer and attract many more applicants, says Melissa Denton, workforce and economic development director at Ivy Tech in Warsaw.

Enrollment in Ivy Tech's advanced orthopedic manufacturing skills training program has grown so fast, now at 400 students, that the school has had to move into larger quarters twice since last year.

Funk expects to complete his training soon, although he might pursue a two-year degree: "I just hope someone hires me."

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. GOHMERT) is recognized for 5 minutes.

(Mr. GOHMERT addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from North Carolina (Mr. MCHENRY) is recognized for 5 minutes.

(Mr. MCHENRY addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona (Mr. FRANKS) is recognized for 5 minutes.

(Mr. FRANKS of Arizona addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. WESTMORELAND) is recognized for 5 minutes.

(Mr. WESTMORELAND addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from North Carolina (Ms. FOXX) is recognized for 5 minutes.

(Ms. FOXX addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. POSEY) is recognized for 5 minutes.

(Mr. POSEY addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mrs. BACHMANN) is recognized for 5 minutes.

(Mrs. BACHMANN addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes as the designee of the minority leader.

Mr. AKIN. Mr. Speaker, this evening we're going to be continuing on a familiar theme for many, probably the single issue that rivets the attention of Americans perhaps more than any single debate and discussion and, that is the change to American health care. This is not, of course, a small debate. It is a debate that involves a question of, to a large degree, whether the government is going to take over 18 percent of our economy. That's not a small section of our economy, 18 percent, nor is it a small question.

Not only economically is it a big question, every one of us has to live inside our own bodies. So it is a very personal question. We have to live inside our bodies, and we're dependent on health care, and we hope that we can continue to enjoy the high quality of health care that we have had in America.

But people recognize that there are problems with American health care. Those problems largely are not so much in the delivery of the health care but rather in how the health care is being paid for. So there are stresses in the system as to who's going to pick up the tab on it.

We've seen a lot of examples of different departments of the Federal Government. It does amaze me just in a commonsense point of view why people would really want to trust their own personal health care with any department in the Federal Government when I think of the profound inefficiencies within many departments of government.

We don't think of the post office as being a model of efficiency, the IRS as being any particular model of compassion or precision. If you think about the Energy Department, the Energy Department was founded on the idea that we had to make sure that America never had to rely on foreign sources of energy. Since that time, the Energy Department has grown in employees, and we have also grown on our dependence on foreign oil.

Then you've got, of course, the Education Department. That is a model of something that I wouldn't put my trust in. In fact, there was a study done on the Education Department some years ago that concluded that if a foreign nation had done to America what the Education Department had done, it would be viewed as an act of war.

Yet there are people in spite of this—and we've seen the Federal emergency management in response to Katrina and other departments of the Federal Government. In spite of that, people want to turn over 18 percent of our economy to the government.

Well, when the government does too much, there are some things that we tend to see as becoming problematic. One of them is that you get some inefficiencies. You could get excessive expenses, degraded quality, or bureaucratic rationing.

□ 1700

Is this something we need to worry about when we are talking about health care? Somebody quipped that if you think health care is too expensive now, just wait until it's free. We will take a look.

Here is what was proposed in the House plan, right here. It's a 1,000 page bill, but you can summarize it in this nifty flowchart. All of the colored boxes are new parts, new moving pieces.

You could see that it certainly doesn't meet the test of simplicity, that's for sure. People who have looked at this and studied it long enough say, I want to be the health care czar. He's the guy who makes all the decisions and determines who gets care and who doesn't.

Tonight, we are going to be talking on the subject of health care. A lot of new information is breaking, new estimates from the Senate as to how much their plan is going to cost and how much is going to be taken out of Medicare on that plan.

I am joined by some good friends of mine here, and I am thinking my friend GT is here. I am just going to recognize and yield to you, my friend, a Con-

gressman who has not been here that many years and yet who has already earned a reputation far in proportion to the amount of time he has served, and long on the common sense department, which I think we need a whole lot more of that common sense.

Mr. THOMPSON of Pennsylvania. Well, I thank my good friend and, actually, 10 months, just about 10 months is what I have been here. The world I came from, actually, was the health care world. I mean, I had spent 28 years working in health care services as a therapist, health care manager in rural hospitals, licensed nursing home administrator.

I came here knowing with a commitment that we could do better with the health care system we had, that we can improve all four principles of health care: access, affordability, quality, and choice.

Mr. AKIN. Slow down just a minute now. The four basic principles of health care, do that again.

Mr. THOMPSON of Pennsylvania. Access, affordability, quality, and choice.

By choice, I mean strengthening that vital decisionmaking relationship between the physician and the patient, and not having the government or a bureaucrat being wedged between those two.

Mr. AKIN. Doctor-patient, yes.

Mr. THOMPSON of Pennsylvania. Doctor-patient relationship, yes. I happen to think we have a pretty good system. Not that we couldn't improve on it. I came with ideas on how to do that. Unfortunately, the ideas I brought with my almost 30 years of experience have been largely ignored by the majority side, by the Democratic Party.

I find that the proposals put out there, specifically House Resolution 3200, in many ways I can find where that proposal, that the Democratic health care proposal, would make all four of those principles worse.

Mr. AKIN. That doesn't sound like a very good idea. Just probing a little bit, though, you made a comment. You said that you came here with 20-plus years of health care experience. You came here with ideas that could improve the system, and we have been accused for months, both by the President and others, as saying the Republicans don't have any ideas, yet you had quite a few ideas.

Mr. THOMPSON of Pennsylvania. Absolutely. I am proud that, as Republicans, we have over 30 bills that we have introduced that would specifically address the different issues and the concerns that I came with, and many others, the visions of my colleagues, that I think would be good to address the health—

Mr. AKIN. Let me ask you this. Did any of your proposals—because we have been accused of this as well, did any of your proposals raid money out of Medicare?

Mr. THOMPSON of Pennsylvania. Absolutely not.

Mr. AKIN. Yet the Democrat proposal we were talking about 2 weeks

ago was raiding \$500 billion out of Medicare. Now, that has been scored in the Senate. It's about 400-and-something billion being taken out of Medicare to try and pay for this thing. That wasn't something you were proposing?

Mr. THOMPSON of Pennsylvania. No. Especially when you are looking at proposals to raid Medicare specifically, the hospice services, people that are preparing their lives to die with dignity, to die in their own homes and places surrounded by their family and can be comforted in a way that provides that dignity to those final days. And to cut Medicare in that area is just wrong.

I think that what I find most interesting about that proposal to cut Medicare to fund this new large government-run program, sweeping government-run program, is that it's, in my experience, as I look at the issues surrounding—and this is some of the things I came with—the issues surrounding a wide commercial health insurance is so expensive, and it is in many places.

The average health insurance pays, nationwide, 140 percent of cost to hospitals and to physicians. The reason for that is—there are many reasons, and we will talk about them this evening, like tort reform, but the other reason is Medicare. It's medical assistance.

Medicare pays, on the average, 90 percent of the costs. For every dollar of costs a hospital has or a physician has, Medicare pays 90 cents. For every dollar of cost that a hospital or a physician has, medical assistance pays, varies State by State, but 40 to 60 cents. Within our health care system, because the government set up these entitlements and soon found that it couldn't sustain them, couldn't afford them and begins to systematically underpay them, we look to commercial insurance to make up the difference.

It's interesting that Medicare is the reason, I think, one of the primary reasons why commercial insurance is as expensive as it is, yet the proposal is to make more Medicare cuts.

Mr. AKIN. Here, this is a chart of these three big entitlements. People talk sometimes about earmarks and other stuff about Federal spending. But the real story about the Federal budget being broken is really within these three big entitlements. All of them, you can see, are growing out of control over time: Medicare, Medicaid, Social Security.

Now, as these things grow, what you are saying is, in spite of the fact it's costing a ton, there is still not enough money in those programs to really pay for what the medical costs are. We are now taking money out of the private sector or from other sources to help subsidize these things that don't work.

Now, you are a commonsense guy. It seems to me that if we have Medicare and Medicaid that are financially broken, the solution to say, well, we are going have the government take over all of that and a lot more, that almost defies common sense.

You know, we are joined by a gentleman whose sagacity and also years of service on the floor are about legendary. Congressman SOUDER, I would appreciate you joining. I think of these as kind of a dinner conversation. Let's just talk about what we have got going on. This is something that Americans care about all across our country, and I think we need to have enough time to talk about it, take a look at it, and to say just say rationally what's the right thing for us to be doing.

Mr. SOUDER. Right, and you have taken the lead here on the floor. Trying to make sure we present this, I have got a couple of specific points, but one, which you are doing through this, is at a minimum, the public needs to know what's in the bill, and the thought that something may come here without 72 hours to read it, which is not a long time, is just abhorrent.

Mr. AKIN. This is not really a particularly subtle point, yet the American public understands this. They would like us to read the bill. It's really hard to read the bill when the bill we are debating and voting on is still being collated up here, like the cap-and-tax bill that we had with 300 amendments passed at 3 o'clock in the morning.

Your point is well taken. First of all, it would be a good idea to see what the bill is before we vote on it. It seems like a straightforward point.

Mr. SOUDER. The other body passed a Senate Finance bill, which has correctly been called a conceptual bill, that we heard the budget estimates of that bill. But as they said in the notes, in their report, you can't hold us accountable for these estimates because the bill doesn't specify how they are going to achieve certain savings, doesn't specify how certain things are going to be paid for, doesn't specify exactly what they are covering. It doesn't give enough specifics.

Even when you are taking over this big a sector of the economy, 1,000 pages is like a sneeze at this problem. There has to be not only 72 hours to read it, but we need to actually see a real bill, not a conceptual bill.

Now, there are a couple of things. Our friend from Pennsylvania alluded to this one. We have had this huge controversy about the so-called death counselors that are clearly in the bill to do counseling in the last 5 years of life and if your condition deteriorates. Many of us are strong supporters of hospice care. I think a lot of people thought this was for hospice care, but they are getting cut 18 percent. I just read a letter from someone in my district that says we don't know how our hospice care can survive with these cuts. What is the point of these counselors if you are wiping out the hospice care?

No wonder some people are a tad paranoid. I don't know what it means. How can we know what it means? What we know is it looks like they are rationing because they are cutting off services to Medicare.

Mr. AKIN. This is death care?

Mr. SOUDER. Well, it says they will present all the alternatives. But I assume that the real intent around that was to promote hospice care. But if they are cutting hospice care, and the hospice centers don't know what they are doing and you are rationing certain life supports, and if they are talking about how much is spent in the last years of life, this is really disturbing stuff.

That's why we have to read the bill. We have to know precisely what's in it. What do you mean when you put that kind of stuff in?

Where that section was on our House bill referred back to the Social Security act. It didn't even fit. The counseling part didn't even fit. Nothing else in there was counseling. It was things like liver and all this kind of stuff. It was incredibly sloppily written. It will be forever litigated.

It seems to set up a pattern where you are going to be counseled and given a different alternative from hospice to euthanasia. You are going to be told you are going to get things reduced, or at least they should disclose that. But if there is no hospice that can survive, particularly in the smaller markets—which brings up another critical point. The cardiologists were here on the Hill just a couple of weeks ago.

Mr. AKIN. As you talk, what comes to my mind, as I am hearing you talk, is basically a form of rationing that's really diabolical, a sort of rationing that says, well, you can take a bottle of aspirin or what. I am getting to be an old codger at 62, but if I were older, I would be even more paranoid, I think, from what I am hearing you say was in the bill.

Mr. SOUDER. The challenge here is that people are confused. You hear the President or others say it's not in the bill, then you hear the Republicans make an allegation.

Here is the thing. It doesn't specify, A, if we could read the bill, but what we see doesn't specify. What it does say is there will be counseling. In another section it says there's going to be savings, which implies rationing, and in another section—or implementing and procedures, a cut for hospice care.

In another part of it it says, the first part says 5 years. Nobody knows exactly what that means, every 5, once in 5, not explained. Then later it says if you have a condition change. When you put those together, you come to a logical conclusion.

But then the other side goes, well, it's not in the bill. Well, not precisely, but it's in there in five different places, and there is no other way to resolve it. There has to be some kind of unit that has to put this together to make these kinds of decisions.

In this waste and abuse, one of the questions is what does waste and abuse mean.

The cardiologists were in the other week, and the oncologists the week before that, because they were concerned

because they have started to implement some of these procedures. What we hear is that, well, if there is waste and abuse, why aren't we checking it right now.

Well, they are defining waste and abuse as underutilization of equipment. What does underutilization of a heart machine mean? What does underutilization of a heart center mean? What does nonefficient usage of oncology machines mean?

In Indiana, what it means is everybody goes to Indianapolis. You are going to close your heart centers in Fort Wayne because you have a utilization of 44 percent, not the 80 they are mandating. It means South Bend, Evansville, northwest. In Missouri, maybe you get Kansas City and St. Louis.

We had a number of Russian health care administrators in my district as well as people from the Duma a number of years ago. We took them to some of our hospital systems. They said we have seen most of this stuff in Moscow. What's unusual even in the United States is that even in towns of 15,000 you have hospitals like we have in our big cities.

When we hear about lines in Canada and England, it's partly because, to be efficient, they have people drive 200 miles to a heart center, and they get to pay the mileage. They get to pay for the motel. They get to go back for repeat visits and the cost to them. That's not savings of waste and abuse; that's transferring the fees to individuals.

What we have right now is a dispersed health care system that brings it closer to home with what we call RediMeds in our area. You have blended regional hospitals feeding up to bigger hospitals. They seem to think that these savings are going to become like they were trying to do in the veterans hospital system in Indiana and make everybody go to the biggest city in the State.

Mr. AKIN. What strikes me, gentleman, and your points are very, very, well taken, currently full of waste and abuse. It's almost like you have a line item on a budget that says waste and abuse and so many million dollars. I mean, if you had that, you take that line item off the budget. Well, what exactly does waste and abuse mean?

We were just talking to cardiologists today that came in. They explained the kinds of equipment they have in their office. From a practical point of view, if you are a cardiologist, it's like what used to be a stethoscope. A doctor hung it around his neck. He might not have used it all the time, but he needed it on a fairly regular basis.

Their stethoscopes now are far more sophisticated, but they use them all the time. Not all time, but they have to have them immediately available to do their job. As you say, that allows them to provide service reasonably close where people live, and it allows them to do it right in the office. Particularly, it provides the fact you don't

have to wait weeks and weeks to get some particular checkup.

That is the weak underbelly of the socialized medical systems in England and Canada, because you take a look at things like cancer, you don't want to wait weeks and weeks. If you have got melanoma, you want to get it and you want to get it now. If you have got heart disease, you want to get it now.

□ 1715

I just went through this with my father. He got a new heart doctor. His old heart doctor wasn't paying too much attention. His new heart doctor took a look at him, took a look at his meds and said you need to get a chemical stress test. When he got that, he said you need to get an angioplasty thing. So they go in and look around with that. They said when you get that, you need to get a heart bypass, which turned out was a seven-way heart bypass. When he got done with that, 4 days later he is home. Total period of time, less than 3 weeks from the time he went in to see the doctor until he had a seven-way heart bypass and was home from the hospital.

That is the American medical system, because it can react quickly and rapidly to something that if you let it go is going to be life threatening. That is what you are talking about.

So this waste and abuse, we have seen where some of this supposed waste and abuse is coming from; \$500 billion out of Medicare. I know Republicans have been accused for years of being people who want to cut Medicare. Here we have got the Obama plan, we are going to get the money out of Medicare.

In fact, you made the point, gentleman, that we hear these conflicting claims and people say, Well, what's the truth?

Here's what you need to know: "First, I'll not sign a plan that adds one dime to our deficits, either now or in the future." This is our President. He says he is not going to add a dime to our deficits. Guaranteed, first thing. Well, let's take a look at the track record since the beginning of the year.

Deficits. We are talking trillions of dollars worth of deficits here. Here is the Wall Street bailout, the second half of that. Economic stimulus. If you don't vote for this, you might have over 8 percent unemployment. So all these liberals voted for this thing, \$787 billion, mostly in handouts and welfare types of things; and now we have got, whatever it is, 9 percent unemployment.

Mr. SOUDER. Maybe he meant that he wasn't going to add one dime, that he was going to add a couple of trillion.

Mr. AKIN. Maybe that's what he meant, it wasn't a dime, it would be trillions of dollars. But this doesn't give us any record to be comfortable with. This assertion doesn't square with what our history is.

Now, there have been a number of other assertions. This is what makes people confused.

First, if you are among the hundreds of millions of Americans who already have health insurance through your job, Medicare or Medicaid or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have. The President is saying this. You get to keep what you have got. If you like what you've got, you can keep it.

Yet here you have an MIT health economist, with or without reform, that won't be true. His point is that the government is not going to force you to give up what you have, but that is not to say that other circumstances won't make that happen. Essentially, what happens is the government gets into the insurance business, the other privates all close down, and you only have one choice: you have got to go to the government.

So one thing you are hearing, you can keep what you have. In fact, here is a guy from outside that doesn't have a dog in the fight, he says that is not how it's going to work.

Here, this is a section, the doctor-patient relationship. If there is anything important in medicine, it is the doctor-patient relationship. This is an amendment that was offered by Dr. GINGREY from Georgia, one of our friends and colleagues. Here is his amendment:

"Nothing in this section shall be construed to allow any Federal employee or political appointee," that is bureaucrat or whatever, "to dictate how a medical provider practices medicine."

In other words, we are going to enshrine the doctor-patient relationship. We are going to make it clear that when a doctor and patient decide on a particular procedure, we are going to proceed. Nobody is going to get in the way. Not only do we not want the insurance company getting in the way; we don't want any bureaucrats.

So he puts this amendment up and it goes to a vote in committee. Most people don't know this amendment went to a vote in committee and here is the result: 23 Republicans say, yeah, we want to leave that doctor-patient relationship sacred. And where were the Democrats? Thirty-two of them voted against this, only one voting for it. So what confidence does that give you that we're not going to get a rationed health care system? And yet we're saying whatever you have, you can keep it. We've had these claims and counter-claims, and I think it's important for us to let the American public shed some light on this. This is what people are saying.

I've got some other charts, but I want to go to my good friend from Pennsylvania. I yield.

Mr. THOMPSON of Pennsylvania. I appreciate that, and I thank my good friend.

I want to come back to the waste and abuse claim, that in addition to obviously significant taxes, that there's all these savings under waste and abuse. It's being presented and proposed by the Democratic Party like this is something new that we're looking at.

I have to tell you that I was working in health care in 1983 when diagnostic-related groups and the first prospective payment system came into health care. Soon after that, we began to hear about and work on eliminating fraud and abuse. Professionally and ethically, that's a responsibility that health care professionals have to do. The fact is that is something that has been ongoing. So now this claim that we're going to find these massive amounts of money as a result of waste and abuse that we can use and save and help to fund this government-run health care program is just false, absolutely false.

Now I do think there's waste in health care, and I can point to annually \$26 billion. We can take \$26 billion annually, and we can find that like this if we had the courage of my colleagues on that side of the aisle to address medical malpractice.

Mr. AKIN. Gentleman, you've got all of our curiosity up. How can we get \$26 billion? You say there is a line item of \$26 billion that you could work on.

Mr. THOMPSON of Pennsylvania. There are line items in physician budgets, in hospital budgets; and we could eliminate that cost to health care today by passing medical malpractice tort reform.

Mr. AKIN. Oh, tort reform.

Mr. THOMPSON of Pennsylvania. Tort reform. Premiums annually in this country are paid in the amount of \$26 billion. The average award under malpractice is \$4.1 million in this country. And so there's a line item that actually is in health care budgets and all the providers across this Nation that we could take that money—and we've got great proposals. The Republicans have H.R. 3400 that's out there that would address tort reform, that would do it in a way that would limit punitive damages. It would set up panels to be able to deal with those situations using judges that have health care experience.

So we have bills out there that if we could get our colleagues' support tomorrow or today, we could actually eliminate what I consider \$26 billion of waste from health care.

Mr. AKIN. I think my friend from Indiana had a comment on that. I yield.

Mr. SOUDER. I beg to differ just slightly. While that's the amount that people pay, what I hear from doctors in my district—and we have MedPro, which is one of the biggest insurers of doctors—that that's just part of the cost of defensive medicine. After the doctors are told to keep your insurance down, make sure they get an MRI if they're questioning at all rather than extra x rays so they can't sue you, make sure you do this extra test, that doesn't count all the things that they do to try to avoid their rates from going up. We don't know what the cap is.

The problem with the studies that claim you don't save as much from tort reform by those who are proponents of

it literally do not take into account what doctors are saying in their daily practice of things that they wouldn't do at the margins if they didn't think there was a potential of being sued that would drive up the rates.

Mr. THOMPSON of Pennsylvania. Will the gentleman yield for one quick point?

Mr. AKIN. Yes.

Mr. THOMPSON of Pennsylvania. There was a recent study done just in Pennsylvania that showed that 93 percent of physicians in Pennsylvania practice some form of defensive medicine. Ninety-three percent, for that very reason. You invest \$200,000 to a half a million dollars in a medical education career and then because of these lawsuits and because of medical malpractice and the lack of tort reform, you're at risk of losing not just your practice but your family's home. I understand why defensive medicine occurs. We've got the solution. H.R. 3400 would address that.

Mr. AKIN. We've been talking about how do you deal with some of the different questions in health care. What has just been illustrated here is the fact that Republicans do have a number of ideas. One of those is tort reform. You're not talking about the fact that if a doctor makes a mistake that the patient shouldn't be made whole; but what you're talking about is this wild, punitive damage kind of thing which just introduces such a wild card for the insurance companies that they run the cost of insurance up and then the doctors practice all this defensive medicine, which my friend from Indiana is pointing out as well; and any doctor you talk to will explain that that's just standard. We don't necessarily like it, but politically the Democrat Party doesn't want to allow dealing with that tort reform.

Now, the President did make a comment about it, and it is kind of the elephant in the room, but it's a big cost to health care that could be dealt with.

We're joined also by my good friend from Louisiana, Congressman SCALISE. Please join us.

Mr. SCALISE. I want to thank my friend from Missouri for hosting this and for helping to continue this debate to really get the facts out about some of the dangers of the proposal being brought by President Obama, Speaker PELOSI and others to really have a government takeover of health care. I agree with most Americans in this country who recognize that there are problems in the system but also recognize that with those problems we still have some of the best medical care in the world and we surely don't want to see the government come in and take over health care and destroy the things that work all in the name of fixing the very specific things that are broke.

If you talk about medical liability reform, doctors will tell you that many of the tests, maybe a third of all of the tests and procedures that are run on people, are just purely in defense of

trying to avoid a frivolous lawsuit. Experts will tell you you could save about a hundred billion dollars—billion with a B—a year in medical savings just by doing something to eliminate the frivolous lawsuits and address medical liability reform which, as my friend from Pennsylvania points out, we do in the bill that I'm a cosponsor, many of us are cosponsors of, H.R. 3400.

Not only that, for Americans who have to go through these tests and procedures that they know they don't have to go through and they wonder, why do I have to go through these CAT scans and these other tests that my doctor really doesn't think I need but because he's afraid of a lawsuit, I've got to spend the extra time and the extra money.

Outside groups have now come and just earlier this week, Pricewaterhouse said that the bill being brought by President Obama and others in Congress would add another \$1,700 a year to the average American family's health insurance cost.

Mr. AKIN. Wait a minute now. You got my attention. The average American family, the proposal that's being offered is it's going to add \$1,700 more a year for the cost of their medical insurance?

Mr. SCALISE. That's exactly what the Pricewaterhouse study says.

Mr. AKIN. Isn't that the new study on the Democrat Senate plan? Isn't that where that was done?

Mr. SCALISE. Right. Because as we're getting more information on this bill that just passed out of the Senate, they still won't put the legislative text out there, and I think we should have at least 72 hours where the bill is available online so that not only Members of Congress but all Americans can read it, but also as they're starting to research and look at all of these taxes.

The Democrat bill in the Senate has \$400 billion in new taxes that would be passed on to American families. The House bill has \$800 billion in new taxes. All of that will raise the cost of health care.

Mr. AKIN. Let's talk about cost. You've got \$400 billion in new taxes, and you're going to take another 400 or \$500 billion out of Medicare. So right off the bat when you say, Here's this new piece of legislation, what do I get for it, well, first of all, \$400 billion in taxes, 400 or \$500 billion out of Medicare. That's something, just as we started talking. It raises this kind of commonsense question: You've got over a hundred million Americans that have insurance and doctors and health care that they like pretty well, and they don't really want to change; they're content with what they've got, and in order to try to fix what problem, you've got somewhere between 10 and 20 or 10 and 30 million who don't have health care, maybe could afford it but don't. And so in order to do the 10 or 20, you're going to basically take apart the system for a hundred, which also raises kind of a commonsense question, too. I just don't quite see that.

There are a lot of claims going on. Here's one:

"There are also those who claim that our reform effort will insure illegal immigrants. This is false. The reforms I'm proposing would not apply to those who are here illegally." This is the President. This is his claim. But let's take a look and see, well, what does the fine print say.

This is the Congressional Research Service. This is a nonpartisan group. They've studied the bill that the President was talking about. They say:

Health insurance exchange would begin operation in 2013 and would offer private plans alongside public option. H.R. 3200—that's Speaker PELOSI's bill—does not contain any restriction on noncitizens. It does not contain any restrictions on noncitizens, whether legally or illegally present or in the United States temporarily or permanently participating in this exchange.

Mr. SOUDER. Will the gentleman yield?

Mr. AKIN. Yes, I do yield.

Mr. SOUDER. Can you imagine the outrage in America if liquor stores posted on their door, No IDs checked here? If you went to a gas station where we assume that tobacco cannot be sold to minors but you had a sign that said no IDs checked here, would you believe that the liquor store or the place selling the tobacco isn't going to sell to minors? On what basis? In effect, what we're telling them in this bill, no IDs checked here, so how do you know?

Mr. AKIN. Isn't that amazing? This is why Americans to some degree are upset. They're upset about the points you made. They would like us to have 72 hours to at least look at a bill and read it.

□ 1730

And then, they're not too fond of the idea they're going to get cracked for \$400 billion or \$500 billion taken out of Medicare. Certainly senior citizens aren't too fond of that. Some people don't like the idea of having to pay for illegal immigrants' health care services. This is very clear from the Congressional Research Service that what the President said just flat isn't true.

And if that were not enough for you, here's an amendment by one of our colleagues, Congressman HELLER. This is another one of these amendments that takes place in committees where people don't see it so much. This is going to clarify this statement that the President made. In order to utilize the public health insurance option, an individual must have had his or her eligibility determined and approved under the Income Eligibility Verification System, IEVS, and the Systematic Alien Verification for Entitlement, SAVE programs under section 1137 of the Social Security Act.

So, in other words, what we're saying is, we're going to make sure, we're going to card you at the liquor store. When you buy those cigarettes, we're

going to card you. That's what this amendment says. You notice it says "failed" down here at the bottom. It failed why? Well, because here's the Republicans. They all voted for it. Here's the Democrats. They all voted against it. There are more Democrats so this amendment is history.

So the President says, we're not going to have any illegal immigrants, but, in fact, the Congressional Research Service and this amendment and the vote on this amendment bears testimony that that just isn't true.

Mr. THOMPSON of Pennsylvania. Will the gentleman yield?

Mr. AKIN. I do yield to my good friend from Pennsylvania.

Mr. THOMPSON of Pennsylvania. I'm not sure which committee this is representative of, but I serve on the Education and Labor Committee. And in that approximate period of time of around July 16th, the next to the last week in July, we were also presented with H.R. 3200, and we were presented with it and went into within 48 hours of when we were given the first copy, which was 500 pages of the bill, and then that was on a Wednesday. The very next day, on Thursday, we started bill markup, which is an important event around this place. It's where we make substantive changes to bills. And at that point, the bill had grown, with a manager's amendment, to over 1,000 pages. And we started a marathon markup that started at 10 a.m. on a Thursday and was driven by the leadership of the Democratic party until 5 a.m. on Friday, 20 hours. I can't tell you the—

Mr. AKIN. Till 5 'o clock in the morning?

Mr. THOMPSON of Pennsylvania. 5 'o clock in the morning. I can't tell you—you can imagine what the quality of work was after about 11 p.m. But some time during those wee hours of the early morning, probably between 1 and 3 a.m. I specifically remember that amendment coming up and being debated, and debated passionately, that we have a responsibility to the American citizens to be able to be good stewards of the resources that are here that we have as a country, and that we have the responsibility of overseeing. And I remember that amendment, and specifically how it was defeated, along a party line, with all the Republicans voting for that amendment and the Democrats opposing it.

Mr. AKIN. This is the illegal immigrants getting access to the money of Americans that are paying money for health care.

Mr. THOMPSON of Pennsylvania. That is correct.

Mr. AKIN. I do yield to my friend from Indiana.

Mr. SOUDER. Also as a member of the Labor Committee, my friend from Pennsylvania and myself and probably three others, I thought, were actually very articulate in arguing some of these amendments at 3 in the morning. Our audience wasn't very big. You

know, when people say, oh, what happened, why didn't you guys—I mean, the only place we can offer amendments usually is committee. We don't get to offer them here on the floor.

Mr. AKIN. Just for some people that might not be familiar with the way the House works, when this bill, this medical bill, whatever it is that the Democrats come up with, it comes to the floor, they're not going to let us offer any of the amendments that are going to be in any way embarrassing or debate them or discuss them. It's going to be a take-it-or-leave-it. The train is leaving; either get on or stand on the platform with your hat in your hand.

Mr. SOUDER. Putting aside that that may be why they don't bother to let us read the bill, because we can't amend it anyway, that you would think that there would at least be some public responsibility to give us 72-hour notice. In committee, we didn't get 72 hours. As my friend from Pennsylvania, Mr. THOMPSON, has pointed out, it was just, I mean, we got it basically when we sat down, the final bill. Then we're debating it in the middle of the night, which the other party said was shameful when the Republicans held a vote because of the debate which was actually on the floor. We don't do debates in the middle of the night anymore because we don't do debates, we don't offer amendments.

But in the amendments in committee, the amendments on pro life, the amendments on trying to check ID, the amendments on a lot of these controversial provisions, nobody got to see the very eloquent debate. I thought we were pretty eloquent at 3 in the morning. You know, I took a little offense. I thought we were fairly good but nobody will witness it.

Mr. AKIN. Well, let's just review a few of those amendments. The first thing is, you don't want illegal immigrants to be tapping into the money for the health care. Another one was saying we weren't going to use health care to pay for abortions. So that was one that, I mean, a lot of Americans are thinking, I don't really want my—whether you're for or against abortions, I'm not sure I want my money being used to give people free abortions. And then there was a question about the doctor-patient relationship. Are we going to ration health care with bureaucrats, some calculator, some computer that says, well, at your age and at this and such, you don't get any?

And so you've got an amendment that says that you're going to have a doctor-patient relationship that is going to be sacred, and that you're going to allow the doctor and patient to make medical decisions. All those amendments offered in committee go down on a straight party-line vote.

Mr. SOUDER. Another one for a second that you referred to earlier. That, you know, people can say things. We can stand up and say whatever we want. But when you vote it's your action. And in the action—

Mr. AKIN. A vote isn't an opinion. It's a hard and historic fact, yes.

Mr. SOUDER. Keep your own insurance, keep insurance the way it is? No. It was defeated. We had one that said catastrophic plus an HSA. That means that you could get flexibility to get catastrophic coverage that could be provided by the firm; they give you money so you get an HSA, and then if you want pregnancy coverage you could cover pregnancy. If you were older—like, we're probably not going to have any more babies; it would be a big shock if we did, since I am 59, about to turn 60, and my wife's similar. Much younger of course, but similar. I'm going to get killed when I get home. The bottom line is that we may not want pregnancy coverage, so why can't we get a health policy that's customized? Defeated.

You know, this idea that the Senate bill in their talking points today says they're going to allow you to keep your own insurance. And then further down it says all these new things will be added. Mandatory. By the way, that wouldn't be your insurance. If your insurance doesn't have it, that's not your insurance. Your company would have to either raise the prices or drop your policy. If they're dictating, that's not your own insurance.

Mr. AKIN. And that's one of the talking points as we talked to one of the Senators this morning about the new—because we're getting information about what the Senate is doing, and that was one of their things—it reduces health choices. I think the whole point of the policy is Americans don't all necessarily want the same policy. You know, if you've got a medical savings account, which is something that we have supported, so you can put money aside to cover different things, and you've got a lot of money in that medical savings account, the insurance you may want would be what we used to call a major medical policy. It covers the great big things, but the smaller stuff, you can say, hey, I can afford to take a thousand or \$2,000 hit because I've got enough money in my medical savings account that I don't need to pay for a policy that covers everything.

Somebody else who's just starting, and maybe they're a little bit worried about they just can't take anything, they're going to want a policy that covers a lower deductible. And depending—as you made eloquently clear, one size doesn't fit all. It's not the, You can have any car you want as long as it's black. We've got choices in America. And what this Democrat Senate plan, and it is Democrat, does—there's only, huge news, one Republican, just one, that ventured to vote for this thing; everybody else is against it—it reduces health choices. That's not the way you save money, and it's not the way you provide good health care. Very good points, gentleman. I yield to my friend from Pennsylvania.

Mr. THOMPSON of Pennsylvania. Well, what you're talking about is actually an amendment that I offered in

the Education and Labor Committee to bar the exchange, the health insurance exchange, which essentially allows this new health insurance commissioner to dictate the terms for your private insurance policies. Exactly what my good friend from Indiana was talking about. Specifically, what would be required, as opposed to a consumer in a free market, where I choose what's best for me and my family, a government bureaucrat would dictate if my insurance policy qualifies or not within this exchange. And again, that's an amendment we offered up to eliminate the exchange from H.R. 3200 within the Education and Labor Committee. And that was defeated along party lines.

Mr. AKIN. Another party-line vote. Just amazing, isn't it? Well, you know, if you take a look at what the Senate is talking about doing, you can understand why there's this amazing gap, because the public opinion polls are showing that people are not very comfortable with what we're talking about jumping into, and for the sake of whatever it is, 10 or 20 million people, destroying the health care of 100 million.

And this, these are some of the costs: It raises premiums, and it reduces the health choices which we've been talking about. Those health choices are very important. It delays or denies care. This thing here, delaying and denying care, as a cancer survivor, I understand the importance of this because if you don't get it and get it quick, you're a goner. And so this idea of rationing and postponing and having to wait in queues, which is endemic in England and Canada, that's something that we don't—that's a high cost.

We've got some other costs here. We've been joined by my good friend from Iowa, Congressman KING, and I imagine you might have a few thoughts on these subjects as well.

Mr. KING of Iowa. Well, I thank the gentleman from Missouri for holding this special order. And as I hear the word Iowa, I look across that list and I see \$500 billion in Medicare cuts. And we know that nationwide, Medicare reimbursement rates, the services provided under Medicare, are only compensated under the schedule we have today at about 80 percent of the cost of delivering that care.

And if you look around the country where you have concentrations of seniors, we know that's where the Medicare dollars go. And my district of Iowa, as a State, has the highest percentage of its population that's over the age of 85. And we're in the top six or seven over the age of 65. So we actually do pretty good on the longevity side. And in 99 counties in Iowa, 10 of the 12 most senior counties in Iowa are in my district, so I may well represent the most senior congressional district in America.

And I'm standing here looking at this data that's been out here now for probably 2 months, a half a trillion dollars in Medicare cuts, Medicare cuts. And the administration takes the position

that they're going to find waste, fraud, and abuse. But it's odd that if they know where the waste, fraud and abuse is, why do you have to bargain to get a socialized medicine program in order to go after the waste, fraud and abuse? If you find waste, fraud and abuse in government, don't keep it secret, Mr. President. Tell me where it is. We'll find it here in Congress.

And that's one of my concerns is that you can't bargain that. If it's good policy, eliminating waste, fraud, and abuse is always good policy. You don't hold it out and say, I've got a secret. It's in the envelope—Karnak predicts that if you pass my national health care plan, I can find you billions of dollars worth of savings. But taking it out of our senior citizens' pockets. And it's so interesting to me that I remember my junior Senator, TOM HARKIN, had a political campaign that resolved around a statement that he made, he referenced \$6 billion, and he said, Well that's just pencil dust. And so his opponent walked around with a man-sized pencil the whole campaign showing \$6 billion is not pencil dust.

But I recall the spokesperson for the AARP sitting on a national cable news program, referring to the half a trillion dollars in Medicare cuts, now it does sound like more when it's \$500 billion in Medicare cuts, referring to it as a small percentage of the overall outlays. Half a trillion dollars, a small percentage of the overall outlays. That's one of the pieces of the bullets that you have there.

Mr. AKIN. I'd just like to cut in a little bit on you, gentleman. When you've raised this point that Medicare pays for whatever it is, 80 or 90 percent of the actual cost of a procedure. So what that's saying is, whenever a doctor treats a Medicare patient, what's really happening is there's more cost than actually is being paid by Medicare. So what that means is at a certain point, if you were to reduce what Medicare is paying, there's going to come a point where a doctor says, enough already. I just can't afford to cover any more Medicare patients because, guess what, I'm going to have to cover some other patients, and I'm going to have to charge them 120 percent to make up for the 80 percent over here because we're cost shifting.

So, in other words, what's happening is somebody is having to pay more. So now what we're going to do is take \$500 billion out of this. And what's that mean? Somebody else is going to have to pay more.

Mr. THOMPSON of Pennsylvania. I think that you are just going down a line, a road that is so important in this debate. It really comes back to where we started talking about rationing. And the ultimate form of rationing, to me, is where you have to close hospitals, especially in a congressional district like mine, and probably a number of my colleagues here are very rural; to get to another hospital when one closes is a commute that makes a

difference between life and death. Hospitals, rural hospitals, and I'm sure underserved urban hospitals in particular, they have a banner year when they make a margin of 1 to 3 percent—1 to 3 percent.

Mr. AKIN. That's not a lot of fat.

Mr. THOMPSON of Pennsylvania. No. Because out of that 1 to 3 percent, hopefully they're able to give some type of cost-of-living adjustments to keep the best and the brightest in terms of physicians and therapists and nurses and health care professionals.

□ 1745

They also need to be investing in new lifesaving technology that is being developed all the time. And so we see these Medicare cuts in particular.

I also put out there the public option, because the public option will pay by statute, what I saw in the Education and Labor Committee, pays Medicare rates 80 to 90 cents on the dollar of costs, essentially what you will do is bankrupt hospitals and physicians. And I project that that will hit first in rural America and underserved urban areas.

That's rationing. When you close facilities, when physicians no longer are in practice because they can't balance their books, that is the purest form of rationing services.

Mr. AKIN. Rationing is something we need to give some thought to.

My good friend from Indiana.

Mr. SOUDER. There's one point I wanted to make sure I got in here tonight, because part of my district is stunned today. The Senate Finance bill yesterday is proposing a tax that ranges from 10 to 30 percent on the medical device industry. Now, when we talk about Medicare, what we're really talking about is they cover not quite variable costs, but cover no mixed costs, and no fixed costs for hospitals or for reimbursement of other things. Private pay pays for the rest of it. And what this bill is in danger of is squeezing or taxing out private pay.

Now what I hear often is why can't we just all go to the Medicare system? The Medicare system, people who are alive today wouldn't be alive if it were based on Medicare reimbursements because the pharmaceuticals wouldn't have been made. The hip replacements that they have, the shoulder replacements, the knees wouldn't have been invented, because the key is R&D. Lilly in Indianapolis, at one point, 60 percent of their profits were from Prozac. Every other drug that was invented was funded with R&D from that. But if they attach an R&D fixed amount to a particular drug, there will be no excess profits with which to experiment.

The orthopedics industry, according to OrthoKnow, an article by John Engelhardt that was just released shows that the tax on the orthopedic, a little town of Warsaw, 15,000 people in that county, is one-third of the orthopedics industry in the world in my district. Three of the five biggest, they

own the biggest companies in Europe, they are looking if this tax goes through and how they move out. This is one when we move up the ladder, we say we're not going to just flip hamburgers, we're going to go up, we're not going to do commodities, we're going to go higher, and then we get up to the higher areas, and we tax them.

Here is Zimmer, the biggest, based in Warsaw. Their R&D budget was \$194 million. The tax under the Senate bill is 94.7. Stryker—

Mr. AKIN. Wait. Wait. You're going too fast for me. This is absolutely incredible. What you're saying is one of the most brilliant parts of American health care has been the innovation, has been all the new drugs, the new devices, the new procedures. As I mentioned, I'm 62 now. I have gotten to be an old geezer, and my left hip has been giving me trouble. You see me limping around, and I'm going to be looking at a hip replacement. Those weren't available 25, 30 years ago.

Mr. SOUDER. Commodities. The head and founder of Biomet, Dane Miller, talks about in here, they didn't think titanium was going to work. He had somebody serendipitously put into his arm titanium. He walked around with it for 12 years and proved it worked. And they said, wow, this doesn't disintegrate. They used to use basic pieces of wood as your hip. Now we customize it. We try to make it so that when soldiers get hurt on the battlefield and they are 18 years old, they're not going to die in 5 years. Is this going to be flexible enough? How is the skin and bone going to go around it? Michael Porter points out, innovation comes when you have a cluster and there's competition. You destroy that, you take away the R&D. Medicare doesn't pay for that. Private pay pays for that.

Furthermore, Zimmer is proposed to be taxed half. Stryker is proposed to be taxed half. Smith & Nephew is proposed to be taxed half of their R&D budget. Biomet, \$82.2 million in research; \$60.9 million is their tax. Because they were doing readjustments last year, they didn't even make any money.

Now, how do you think we are going to have a single innovation in orthopedics if you tax half of the R&D? And furthermore, they don't call it a "tax," they call it a "fee," so it is not even tax deductible.

Mr. AKIN. So what I'm hearing you say, gentleman, then, is this. Let's just assume if you're a company, for every dollar you put into R&D, you get the same benefit out. You're saying you're going to slash the R&D budget of some of the big innovators in medicine; you're going to slash it by half because you're going to tax them?

Mr. SOUDER. The little ones get hit harder.

Mr. AKIN. Now England and Canada have had this socialized medicine for years. Are they known for the innovation that those countries have added to health care?

Mr. SOUDER. They come here.

Mr. AKIN. They come here?

Mr. SOUDER. When they need a new hip, the inventions are coming out of Warsaw, Indiana. The parts groups that work at some little companies like OrthoPediatrics, they're working on specialized hips for kids who are 4 years old and 6 years old. Are they going to go to Wal-Mart and pick one up off the shelf? Let's get real here.

Innovation requires competition. It requires investment. The way you keep a cluster, according to Michael Porter in "The Competitive Advantage of Nations," when you have a cluster, you need competition. There has to be innovation every week, how can I get better? And that's driven by profit and by competition.

R&D in England is one of the highest in the world, yet they don't produce new products because the government is most of the R&D. It's not driven for what the consumer wants where the consumer basically rewards the market. And we are going to tax these little ones totally out and the big ones half, and we simply aren't going to get the products. So we don't have the option of going to Canada and England to get it.

Mr. AKIN. So what you're saying, gentleman, is you're going to kill R&D. You're going to kill the development. There are all kinds of people that have cancer that is ticking away slowly. They want some innovation. They are hoping some new drugs or some new procedures are going to come along. We're going to kill that. We're going to get rid of that, and we're going to go to a system that has never worked historically.

Here is a chart. This kind of got my attention, because as I mentioned, I was diagnosed with cancer, but take a look at the cancer survivor rates when you go to the U.K. compared to the U.S., and what you see is that big waiting time and that lack of innovation. You don't live as long when you are over in the U.K. In fact, I was told that when you add up all the cancer times, U.K.'s is a 50 percent survival rate if you're diagnosed with cancer. In the States, it's supposedly considerably higher. So why do we want to destroy a system that is producing this level of innovation?

What you are talking about is free enterprise. And free enterprise needs, first of all, to have people have enough money to be able to invest; and second of all, have that competition and that hub of technology that you're starting to drive and one guy is thinking, Hey, I see what they did. That was a cool device. But I think I could up it one. I could do it even better. And that American process is what has allowed us to enjoy the best health care in the world. If you're a rich sheikh from Bahrain and you're sick, guess where you're going to go? The good old U.S.A.

My good friend from Iowa.

Mr. KING of Iowa. I thank the gentleman from Missouri, and I look at

this data that is there. You didn't read the text below that, the success story here in America in proportion, but U.S. companies have developed half of all new major medicines introduced worldwide over the past 20 years. It happens to also be true that in the United States slightly more than half of the research dollars in the entire world are invested here. Those things are not coincidences. Those things come together. It's almost directly proportional to the research dollars. I'd like to think we are a little better than that. I'd like to think that we have innovative skills and there's something within our culture and our mindset that lets us push even a little harder than that. But what we're hearing from the gentleman from Indiana is that this policy punishes the very most successful among us in this country, and it's likely to drive them overseas.

I had a long conversation with a representative from one of the large well-known medical industries in the country, and they've developed a technology, and I'm not going to define it any more than that it would be transformative from a cure standpoint. And they are looking at deploying that in other countries where they can actually get it deployed more quickly. If that happens, if they can introduce new cures in other countries, the research dollars will follow too, and they will set up shop in those countries. It won't be just customers; it will be our businesses that go, just as we heard from the gentleman from Indiana.

Mr. AKIN. The thing that concerns me is that it's possible for us jumping in haste to some kind of a solution like this because of all the political hubbub that's going on, to jump into something which is going to permanently damage American health care. It's going to irreparably move us in a direction where it's going to be almost politically impossible to recover from. It's a little bit like when you get on the gunwale of a canoe, you put enough weight on it, and you're going to dump it over.

We have a very good health care system, but can it take this kind of a hit? \$400 billion in new taxes. Guess who is going to pay those? Do you think those are rich guys that are going to pay those? That's going to be every plain old working person in this country that is going to be part of that \$400 billion. \$500 billion out of Medicare. Guess who's going to pay that? That's going to be the seniors. And the delays and denied care. Who's going to pay that? That's people with heart problems, people with cancer problems. People will be waiting in line. People will have some bureaucrat controlling their health care.

One of the things that really scares me about this, and maybe I'm thinking of it a little too personally, but we are Congressmen, and one of the things that we do in our office is we try to help our constituents that have a problem with the Federal Government. And

so if somebody needs to get a passport, we go hurry up and try and help them get their passport quicker. If somebody has a problem with a permit or something, WE go call the bureaucrats up and say, Can you help out? What form have we not done? How can we help this? And we try to help our constituents out. Now, I'm picturing I'm on the phone and we've got this kind of system, and I'm getting the phone call that says, You've got some government bureaucrat that just told my dad he can't get a heart bypass. What am I supposed to do?

I yield.

Mr. SOUDER. The chancellor of one of my universities, yesterday, when I was at Turnstone, this fellow that works with kids who have physical disabilities and gets them recreational activities, he said, My dad is a veteran and my mom is now in the hospital, and we tried to check with the Federal Government to get the eligibility benefits. We kept getting taped messages saying the person is there on Thursdays for 2 hours.

That's what you'll get with government health care.

Mr. AKIN. Thursdays on 2 hours. So get in line. That's incredible.

We are about at the end of our hour. I would very much like to thank my good friends representing a host of different States, people with a great deal of common sense, and particularly Pennsylvania, with 25-plus years of being in the medical business. You see this thing, it's like a train wreck that you're seeing in slow motion.

What we're trying to say is Americans, pay attention. We cannot afford to go this deal about taking 18 percent of our economy and giving it to the Federal Government to run. It doesn't make sense. It's going to be expensive. It's going to destroy health care. And in every other regard, this is just a bad deal for everybody.

Thank you so much for joining me, gentlemen.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 2892, DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2010

Mr. HASTINGS of Florida, from the Committee on Rules, submitted a privileged report (Rept. No. 111-300) on the resolution (H. Res. 829) providing for consideration of the conference report to accompany the bill (H.R. 2892) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2010, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2442, BAY AREA REGIONAL WATER RECYCLING PROGRAM EXPANSION ACT OF 2009

Mr. HASTINGS of Florida, from the Committee on Rules, submitted a privileged report (Rept. No. 111-301) on the resolution (H. Res. 830) providing for consideration of the bill (H.R. 2442) to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to expand the Bay Area Regional Water Recycling Program, and for other purposes, which was referred to the House Calendar and ordered to be printed.

THE CONGRESSIONAL BLACK CAUCUS HOUR

The SPEAKER pro tempore (Mr. KISSELL). Under the Speaker's announced policy of January 6, 2009, the gentlewoman from Ohio (Ms. FUDGE) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Ms. FUDGE. Mr. Speaker, I ask for unanimous consent that all Members be given 5 days to revise and extend their remarks.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Ohio?

There was no objection.

Ms. FUDGE. Mr. Speaker, the Congressional Black Caucus, the CBC, is proud to present this hour on issues that concern America's senior citizens. The CBC is chaired by the Honorable BARBARA LEE from the Ninth Congressional District of California. I am Representative MARCIA L. FUDGE from the 11th Congressional District of Ohio, and I am the anchor of the CBC hour.

The vision of the founding members of the Congressional Black Caucus, to promote the public welfare through legislation designed to meet the needs of millions of neglected citizens, continues to be a focal point for the legislative work and political activities of the Congressional Black Caucus today.

Tonight, the CBC will focus its attention on the issues currently confronting our seniors. In his last speech, Hubert Humphrey said, The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped.

The fact that some Americans work their entire life, regularly paying into Social Security and are confronted by poverty in their golden years is indeed a problem, Mr. Speaker.

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The social insecurity facing our Nation's seniors is not a Democratic problem or a Republican problem; it is an American problem, Mr. Speaker. This year's news headlines tell the story: "Seniors Struggle With High Cost of

Housing and Food, Barely Getting By"; "Seniors Struggle to Survive"; "Single Seniors Can't Make Ends Meet"; "Subsidized Lunches in Greater Demand Among Senior Citizens"; "Forty Percent of Senior Citizens Not Taking Prescribed Medicines Due to Budget"; "Senior Citizens See Largest Gain in Credit Card Debt As Recession, Medical Costs Take a Toll."

Mr. Speaker, our country will recover from this recession, but we cannot forget the seniors who struggled before the recession began. Many live on fixed incomes and find it difficult to live under the pressure of high medical bills and the rising cost of essentials like medication, food, and housing.

One of the most disheartening news headlines of 2009 had the title, "U.S. Is Losing Ground on Preventable Deaths." In this story, AARP reported that Americans are dying too soon, although the United States spends \$2.4 trillion a year on medical care, vastly more per capita than comparable countries. Our Nation ranks last when compared to 19 other industrialized nations on premature deaths caused by illnesses such as diabetes, epilepsy, stroke, influenza, ulcers and pneumonia, all medical issues that disproportionately attack and weaken American seniors.

In my district, senior citizens call my office daily. Some call looking for reassurance that Medicare will be strengthened through the health care reform, and others asking questions about the future of Social Security.

One senior called just this past week. He is an 85-year-old man living in public housing. He has an artificial leg which he has had since the age of 11. He is worried that his Social Security check will not cover the cost of the medications he uses for complications caused by his artificial limb if the cost of his medications continues to climb.

I am confident, Mr. Speaker, this Congress will answer the calls and the concerns of these seniors, and I will not rest until all seniors have their answers.

Reports have been looming for years about the long-term financial problems of Social Security. The retirement program is projected to start paying out more than it receives in the year 2016. According to the Social Security trustee, without changes, the retirement fund will be depleted by 2037.

Demographic factors are accelerating Social Security problems. Life expectancy is increasing faster than anticipated. In 1940, a 65-year-old man could expect to live maybe another 12 years. Today it's 15 years, and by 2040, it will be 17 years. The fertility rate is falling faster than expected, from 3.6 children for a typical woman of childbearing age in 1960 to just two today, and a projected 1.9 by 2020.

The elderly portion of the population will likely rise from 12 percent today to 20 percent by 2050, increasing the number of retirees from 34 million to 80 million. The smaller working age population and larger elderly population